HB-0169-0904

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM
PO Box 299 Trenton, New Jersey 08625-0299

R E S O L U T I O N

A RESOLUTION to terminate participation under the New Jersey State Health Benefits Program (which includes Prescription Drug Program and/or Dental Plan coverage).

BE IT RESOLVED:

1. The _____
   Corporate Name of Employer — County

   hereby resolves to terminate its participation in the program (including Prescription Drug and/or Dental Plan) thereby canceling coverage provided by the New Jersey State Health Benefits Program (N.J.S.A. 52:14-17.25 et seq.) for all its active and retired employees.

2. We shall notify all active employees of the date of their termination of coverage under the program.

3. We understand that the Division of Pensions and Benefits will notify retired employees of the cancellation of their coverage.

4. We understand that all COBRA participants will be notified by the Division of Pensions and Benefits and advised to contact our office concerning a possible alternative health, prescription drug, and dental insurance program.

5. We understand that this resolution shall take effect the first of the month following a 60-day period beginning with the receipt of the resolution by the State Health Benefits Commission.

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the

_____
Corporate Name of Employer

on the _____ day of _____, 20____.

_____
Signature

_____
Official Title

_____
Street Address

_____
City State Zip Code

_____
Area Code Telephone #

Please complete the reverse side of this form.

PLEASE COMPLETE AND COMPLY WITH THE FOLLOWING:

A. Employer New Jersey State Health Benefits Program Identification Number

_____

B. Type of funding method with the new contract:

1. Conventionally insured _____
2. Minimum premium _____
3. Administrative Services Only (ASO) _____
4. Other (please list) _____

_____

C. New Health Carrier _____

D. New Prescription Drug Carrier _____

E. New Dental Plan Carrier _____

F. Reason for termination of the State Program _____

_____

_____

_____

G. In accordance with N.J.S.A. 18A:16-21 and 40A:10-25, you must file a copy of your new contract with the State Health Benefits Commission. Please submit a copy of the new contract with this completed resolution.